		FOR OHF USE					

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

I. IDPH Facility ID Number: 0014399

Facility Name: GRANGE NURSING HOME

Address: 901 NORTH 10TH STREET (Number) MASCOUTAH (City) 62258 (Zip Code)

County: ST. CLAIR

Telephone Number: (618)566-2183 **Fax #** (618)566-4462

IDPA ID Number: 370855394001

Date of Initial License for Current Owners: 04/07/64

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501(C)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ROGER W. BAGLEY **Telephone Number:** (618)549-8331
JAMESTOWN MANAGEMENT CORP.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) ROGER W. BAGLEY
(Title) CONTROLLER

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number GRANGE NURSING HOME # 0014399 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	55	Skilled (SNF)	55	20,130	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	55	TOTALS	55	20,130	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,850	374	279	2,503	8
9	SNF/PED					9
10	ICF	6,775	3,973		10,748	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,625	4,347	279	13,251	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.83%

D. How many bed-hold days during this year were paid by Public Aid?
11 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/07/64

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 9 and days of care provided 279

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number GRANGE NURSING HOME # 0014399 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	100,122	1,778	4,781	106,681		106,681		106,681			1
2	Food Purchase		46,204		46,204		46,204		46,204			2
3	Housekeeping	73,767	4,061		77,828		77,828		77,828			3
4	Laundry	29,930	3,061		32,991		32,991		32,991			4
5	Heat and Other Utilities			46,010	46,010		46,010		46,010			5
6	Maintenance	24,061	8,575	25,700	58,336		58,336	294	58,630			6
7	Other (specify):*											7
8	**TOTAL General Services**	227,880	63,679	76,491	368,050		368,050	294	368,344			8
	B. Health Care and Programs											
9	Medical Director			1,500	1,500		1,500		1,500			9
10	Nursing and Medical Records	486,940	11,103	113,629	611,672		611,672		611,672			10
10a	Therapy	1,406		254	1,660		1,660		1,660			10a
11	Activities	20,736	1,802	1,223	23,761		23,761	(128)	23,633			11
12	Social Services	15,335		1,223	16,558		16,558		16,558			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	524,417	12,905	117,829	655,151		655,151	(128)	655,023			16
	C. General Administration											
17	Administrative	41,589			41,589		41,589		41,589			17
18	Directors Fees											18
19	Professional Services			73,327	73,327		73,327		73,327			19
20	Dues, Fees, Subscriptions & Promotions			4,031	4,031		4,031	(1,016)	3,015			20
21	Clerical & General Office Expenses	28,000	3,955	4,226	36,181		36,181	(30)	36,151			21
22	Employee Benefits & Payroll Taxes			102,220	102,220		102,220		102,220			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,723	1,723		1,723		1,723			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			38,940	38,940		38,940		38,940			26
27	Other (specify):*											27
28	**TOTAL General Administration**	69,589	3,955	224,467	298,011		298,011	(1,046)	296,965			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	821,886	80,539	418,787	1,321,212		1,321,212	(880)	1,320,332			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number GRANGE NURSING HOME #0014399 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			44,569	44,569		44,569		44,569			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,892	1,892		1,892		1,892			35
36	Other (specify):*											36
37	**TOTAL Ownership**			46,461	46,461		46,461		46,461			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		19,807	27,740	47,547		47,547		47,547			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,196	30,196		30,196		30,196			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		19,807	57,936	77,743		77,743		77,743			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	821,886	100,346	523,184	1,445,416		1,445,416	(880)	1,444,536			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number GRANGE NURSING HOME # 0014399 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(30)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(300)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(656)	20		28
29	Other-Attach Schedule	106			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (880)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (880)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

GRANGE NURSING HOME

ID# 0014399

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DETAIL FOR LINE 29	$		1
2	ELIMINATE CHAMBER OF COMMERCE DUES	(60)	20	2
3				3
4				4
5	ELIMINATE CONTRIBUTION AND	(128)	11	5
6	ACTIVITY EXPENSE PER INCOME			6
7	RECEIVED			7
8				8
9				9
10	DEFERRED PAINTING - SEE SCH XIX	294	6	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	106		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GRANGE NURSING HOME # 0014399 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	294	0	0	0	0	0	0	0	0	0	0	294	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	294	0	0	0	0	0	0	0	0	0	0	294	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(128)	0	0	0	0	0	0	0	0	0	0	(128)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(128)	0	0	0	0	0	0	0	0	0	0	(128)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,016)	0	0	0	0	0	0	0	0	0	0	(1,016)	20
21	Clerical & General Office Expenses	(30)	0	0	0	0	0	0	0	0	0	0	(30)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(1,046)	0	0	0	0	0	0	0	0	0	0	(1,046)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(880)	0	0	0	0	0	0	0	0	0	0	(880)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GRANGE NURSING HOME # 0014399 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(880)	0	0	0	0	0	0	0	0	0	0	(880)	45

Facility Name & ID Number GRANGE NURSING HOME # 0014399 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GRANGE NURSING HOME # 0014399 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BOARD MEMBERS								$		1
2	CHARLOTTE MEHRTENS	PRESIDENT	BOARD MEMBER								2
3	WILLIAM WOODS	SEC/TREAS	BOARD MEMBER								3
4	SOPHIE TRESER		BOARD MEMBER								4
5	DON SCHAEFFER		BOARD MEMBER								5
6	MILDRED MEINKOTH		BOARD MEMBER								6
7	KENNETH JOSEPH		BOARD MEMBER								7
8											8
9											9
10											10
11	THE BOARD OF DIRECTORS DO NOT PROVIDE DIRECT SERVICE TO THE FACILITY OR RECEIVE COMPENSATION.										11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GRANGE NURSING HOME # 0014399 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number GRANGE NURSING HOME # 0014399 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	NOT APPLICABLE						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number GRANGE NURSING HOME # 0014399 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GRANGE NURSING HOME COUNTY ST. CLAIR

FACILITY IDPH LICENSE NUMBER 0014399

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number GRANGE NURSING HOME # 0014399 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,712 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	CARE FACILITY	30,000	1962	$ 1,064	1
2					2
3	TOTALS	30,000		$ 1,064	3

Facility Name & ID Number GRANGE NURSING HOME # 0014399 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	HOT WATER HEATER AND INSTALLATION	1997	$ 3,476	$ 348	10	$ 348	$	$ 2,610	37
38	NEW SPRINKLER AND INSTALLATION	1997	4,618	185	25	185		1,387	38
39	ELECTRICAL WORKLIGHTS IN GARDERN AREA	1997	1,402	70	20	70		525	39
40	Labor/materials to install water repellant wallcovering &	1997	2,112	141	15	141		1,057	40
41	regrout the existing tile in north hall shower								41
42	Labor/materials to gut the existing nurses station (to be	1997	10,764	718	15	718		5,385	42
43	completed in 1998). Labor/materials to remove and rebuild								43
44	walls to create 2 new office areas, install carpet, paint, and								44
45	install window in new office areas.								45
46	HOT WATER BOILER	1997	2,800	140	20	140		1,050	46
47	CARPET FOR WALL THROUGHOUT THE FACILITY	1997	1,488	99	15	99		743	47
48	Labor/materials to complete the installation of new phone	1998	10,151	1,015	10	1,015		6,598	48
49	lines, lighting, cabinetry, countertops, and wallcovering								49
50	in nurses station. Applied protective panels to door facings								50
51	and wallcoverings down hallways.								51
52	RETUBING BOILER	1998	2,530	253	10	253		1,645	52
53	INSTALL ANNUNCIATOR PANEL	1998	402	21	19	21		147	53
54	INSTALL AIR HANDLER	1999	2,900	145	20	145		798	54
55	Labor/materials to hang wallcovering, paint, and patch the	1999	2,628	263	10	263		1,446	55
56	ceiling in the dining room.								56
57	TOP DRESS ROCK AREAS OF PARKING LOT WITH ROCK	2001	1,900	380	5	380		1,330	57
58	Totally demolish and rebuild 2 distinct bathrooms	2001	26,134	2,613	10	2,613		9,146	58
59	INSTALL AIR COMPRESSOR FOR SPRINKLER SYSTEM	2002	1,519	152	10	152		380	59
60	Relocate 3 radiant heat lines and replace concrete floor	2002	4,674	467	10	467		1,168	60
61	in laundry.								61
62	Replace lights, repair water heater, replace fans, install new	2002	2,749	275	10	275		687	62
63	valves and faucets, replace drain connections, replace sinks								63
64	in individual baths on north hall.								64
65	Demolish existing baths on south hall and prepare for	2002	14,902	1,490	10	1,490		3,725	65
66	renovations. Sand and mudd for drywall patch work,								66
67	reinstall call light and light fixture, realign tub and shower,								67
68	relocate existing toilet, install new toilet, remove existing								68
69	wall, tile, and recepticle boxes, paint ceilings, and wall								69
70	TOTAL (lines 4 thru 69)		$ 857,476	$ 32,318		$ 32,318	$	$ 637,425	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GRANGE NURSING HOME # 0014399 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	29		1963	1963	$ 125,662	$ 2,513	50	$ 2,513	$	$ 104,440	4
5	26		1969	1969	148,564	3,714	40	3,714		129,684	5
6											6
7											7
8											8
	Improvement Type**										
9	SEWER AND WATER			1964	7,560	151	50	151		6,173	9
10	SPRINKLER			1975	27,550		20			27,550	10
11	SPRINKLER			1977	840		20			840	11
12	SMOKE DETECTOR			1976	6,485		10			6,485	12
13	SOLARIUM			1979	26,719	1,089	15	1,089		26,314	13
14	SOLARIUM IMPROVEMENTS			1983	500		25			500	14
15	SEAMLESS FLOOR			1982	2,008		7			2,008	15
16	HEATING AND COOLING			1985	36,010	1,801	20	1,801		35,120	16
17	NEW ROOF			1985	24,000		15			24,000	17
18	INSULATION			1985	3,980		15			3,980	18
19	SPRINKLER			1985	2,187	109	20	109		2,166	19
20	BUILDING ADDITION			1987	272,812	10,104	27	10,104		176,144	20
21	SKYLIGHTS			1988	1,790	90	20	90		1,497	21
22	WINDOWS			1988	1,138	57	20	57		912	22
23	BATHROOM REMODELING			1989	10,065	503	20	503		7,883	23
24	CHAIR RAILS			1989	441		10			441	24
25	SHUTOFF VALVES			1990	3,045	152	20	152		2,244	25
26	DOOR ALARM AND AIR CONDITIONERS			1990	2,425		10			2,425	26
27	HEAT PUMP AND AWNING			1993	4,577		10			4,577	27
28	FENCE			1993	2,931	147	20	147		1,641	28
29	SPRINKLERS, KEYPAD TO PATIO DOORS			1994	1,267	63	20	63		670	29
30	SIDEWALKS, TREES			1994	13,361	668	20	668		6,960	30
31	ACTIVITY DOORS, CODER ALERT, DOOR ALARM			1994	5,346	434	10	434		5,346	31
32	AWNING, EXHAUST FANS			1994	6,204	571	10	571		6,204	32
33	COURTYARD			1996	7,310	487	15	487		4,140	33
34	SOILED UTILITY ROOM			1996	6,751	450	15	450		3,825	34
35	30% DOWNPAYMENT ON FIRE ALARM SYSTEM			1997	2,573	129	20	129		1,096	35
36	BALANCE OF FIRE ALARM SYSTEM			1997	6,226	311	20	311		2,333	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number GRANGE NURSING HOME # 0014399 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 857,476	$ 32,318		$ 32,318	$	$ 637,425	1
2	Renovations of south hall baths continued:								2
3	break up and replace concrete floor to relocate main								3
4	for existing water closet and add drain for new H.C. type								4
5	water closet, repipe water lines for tub, relocate tub in								5
6	recessed wall, relocate piping for bed pan washer,								6
7	replaced plumbing and new floor tile, hang cubicle track								7
8	and curtain, frame and drywall new wall, install handrail.								8
9	Repair kitchen area drains and grease trap, construct dust	2002	11,009	1,101	10	1,101		2,752	9
10	wall, break up concrete in dining area, remove concrete								10
11	stoop, repipe U.G. piping from hand sink and ice maker wall								11
12	install 250 gallon concrete grease trap, extend new sewer to								12
13	south sewer line and tie in, replace concrete								13
14	Gutted and redesigned existing bookkeeper's office, installed	2002	2,160	216	10	216		540	14
15	new flooring, walls, and ceiling, installed new cabinetry								15
16	and workspace.								16
17	Gutted existing solarium, installed new flooring, walls, and	2002	8,342	834	10	834		2,085	17
18	ceiling, replaced windows.								18
19	Removed existing bathtub, shower, and cabinets, moved doorway	2003	23,086	2,546	10	2,546		3,463	19
20	constructed wall and installed shower and 3 toilets.								20
21	Complete new floor tile, paint, and electrical fixtures.								21
22	Install wanderer door alarm system	2004	3,329	166	10	166		166	22
23	Repair roof on east side of north wing and north side	2004	8,326	278	15	278		278	23
24	of east wing.								24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 913,728	$ 37,459		$ 37,459	$	$ 646,709	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GRANGE NURSING HOME # 0014399 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 67,331	$ 6,994	$ 6,994	$		$ 39,329	71
72	Current Year Purchases	1,156	116	116			116	72
73	Fully Depreciated Assets	232,033					232,033	73
74								74
75	TOTALS	$ 300,520	$ 7,110	$ 7,110	$		$ 271,478	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,215,312	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 44,569	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 44,569	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 918,187	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number GRANGE NURSING HOME # 0014399 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 1,892 Description: DISH MACHINE (1785) UHAUL VEHICLE (107)
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number GRANGE NURSING HOME # 0014399 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   WE ONLY HIRE TRAINED AIDES.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39/3;39/2	hrs	$	113	$ 7,969	$ 94	113	$ 8,063	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		60	5,416		60	5,416	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3	hrs							4
5	Physician Care		visits		171	12,817		171	12,817	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/2	# of prescrpts				10,415		10,415	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39/2 39/3				1,538	9,298		10,836	13
14	TOTAL			$	344	$ 27,740	$ 19,807	344	$ 47,547	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number GRANGE NURSING HOME # 0014399 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits	17,753		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	201,690		3
4	Supply Inventory (priced at COST)	11,058		4
5	Short-Term Investments	67,670		5
6	Prepaid Insurance	10,340		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 308,511	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,064		13
14	Buildings, at Historical Cost	914,553		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	299,695		16
17	Accumulated Depreciation (book methods)	(918,186)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 297,126	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 605,637	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 28,220	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	17,352		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,320		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 54,892	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 54,892	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 550,745	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 605,637	$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 809,069	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 809,069	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(269,145)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) GAIN ON SALE OF INVESTMENTS	10,821	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (258,324)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 550,745	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,114,050	1
2	Discounts and Allowances for all Levels	(1,636)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,112,414	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	48,160	6
7	Oxygen	12,235	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 60,395	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,990	19
20	Radiology and X-Ray	1,125	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,115	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	347	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 347	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,176,271	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	368,050	31
32	Health Care	655,151	32
33	General Administration	298,011	33
	B. Capital Expense		
34	Ownership	46,461	34
	C. Ancillary Expense		
35	Special Cost Centers	47,547	35
36	Provider Participation Fee	30,196	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,445,416	40
41	**Income before Income Taxes (line 30 minus line 40)****	(269,145)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (269,145)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,392	1,519	27,080	17.83	3
4	Licensed Practical Nurses	8,741	9,117	144,433	15.84	4
5	Nurse Aides & Orderlies	29,614	33,860	315,427	9.32	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	191	240	1,406	5.86	8
9	Activity Director	1,998	2,088	20,736	9.93	9
10	Activity Assistants					10
11	Social Service Workers	985	1,025	15,335	14.96	11
12	Dietician					12
13	Food Service Supervisor	1,941	2,117	29,873	14.11	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,364	9,679	70,249	7.26	15
16	Dishwashers					16
17	Maintenance Workers	2,046	2,175	24,061	11.06	17
18	Housekeepers	6,728	7,332	73,767	10.06	18
19	Laundry	3,193	3,702	29,930	8.08	19
20	Administrator	1,956	2,160	41,589	19.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,988	2,198	28,000	12.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	70,137	77,212	$ 821,886 *	$ 10.64	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 4,781	1/3	35
36	Medical Director		1,500	9/3	36
37	Medical Records Consultant		420	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		550	10/3	39
40	Physical Therapy Consultant	4	254	10A/3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,223	11/3	44
45	Social Service Consultant	24	1,223	12/3	45
46	Other(specify)				46
47	PURCHASING CONSULTANT		231	19/3	47
48					48
49	TOTAL (lines 35 - 48)	148	$ 10,182		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	16	$ 456	10/3	50
51	Licensed Practical Nurses	1,889	55,728	10/3	51
52	Nurse Aides	3,063	56,475	10/3	52
53	TOTAL (lines 50 - 52)	4,968	$ 112,659		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SHEILA STOREY	ADMINISTRATOR	0	$ 41,589
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 41,589

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
JAMESTOWN MGMT CORP	MANAGEMENT	$ 70,699
HEALTH FINANCIAL SYSTEMS	SOFTWARE MAINTENANCE	78
MIKRON	COMPUTER	1,320
RICHARD BRESLIN	ACCOUNTANT	330
M.D. SERVICES	COMPUTER	360
FREESTONE COMPUTING	COMPUTER	309
M.E.S.	PURCHASING	231
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 73,327

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 24,360
Unemployment Compensation Insurance	5,615
FICA Taxes	62,874
Employee Health Insurance	1,106
Employee Meals	2,007
Illinois Municipal Retirement Fund (IMRF)*	0
VACCINES	614
PARTIES, FOOD, MISC.	5,644
TOTAL (agree to Schedule V, line 22, col.8)	$ 102,220

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	1,979
Health Care Worker Background Check	596
(Indicate # of checks performed 37)	
PUBLIC RELATIONS & DIR ADV (ELIM)	956
NAGNA (137) SAM'S CLUB (30)	167
CORP FEES(5) SUBSCR(103)	108
CHAMB OF COM (60) CLIA (150)	210
DON ASSOC (15)	15
ELIMINATE CHAMB OF COM	(60)
Less: Public Relations Expense	(300)
Non-allowable advertising	( )
Yellow page advertising	(656)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,015

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,130
Seminar Expense	593
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,723

**See instructions.

Facility Name & ID Number GRANGE NURSING HOME # 0014399 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINTING	2001	$ 1,762	3	$ 294	$ 587	$ 587	$ 294	$	$	$	$	$
2													
3													
4													
5													
6													
7													
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13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 1,762		$ 294	$ 587	$ 587	$ 294	$	$	$	$	$

Facility Name & ID Number GRANGE NURSING HOME # 0014399 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **30,196**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **2,007** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **N/A** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.